RISK ASSESSMENT ANSWER SHEET

Medicaid ID:		**Client Name:** Last	First
DOB: / /	**Age:**	**Gender:** Female Male	**Residence County:**
Client Spoken Language:		**Client Phone:**	
HMO:	**IHC ACCESS**	**MOLINA-UT**	**HEALTHY U**
Interviewer Name:		**Office Name:**	**Phone:**

PLEASE USE BLACK INK. Circle the appropriate response.

1. **Would you say your health is:**
   Excellent -1 Very good -2 Good -3 Fair -4 Poor -5

2. **Times stayed overnight as a patient in a hospital**
   Not at all -1 One time - 2 Two or three times -3 More than three times -4

3. **Times visited a physician or clinic**
   Not at all -1 One time -2 Two or three times -3 Four to six times -4
   More than six times -5

4. **Diabetes in previous twelve months** Yes -1 No -2

5. **Have ever had Coronary heart disease?** Yes -1 No -2 Don't know -8

6. **Friend, relative, or neighbor who would take care for a few days?** Yes -1 No -2

7. **Time been a very nervous person?**
   All of the time -1 Most of the time -2 A good bit of the time -3
   Some of the time -4 A little bit of the time -5 None of the time -6

8. **Time you felt calm and peaceful?**
   All of the time -1 Most of the time -2 A good bit of the time -3
   Some of the time -4 A little bit of the time -5 None of the time -6

9. **Time you felt down-hearted and blue?**
   All of the time -1 Most of the time -2 A good bit of the time -3
   Some of the time -4 A little bit of the time -5 None of the time -6

10. **Time you've been happy ?**
    All of the time - 1 Most of the time - 2 A good bit of the time - 3
    Some of the time - 4 A little bit of the time - 5 None of the time - 6

11. **Time so down in the dumps ?**
    All of the time - 1 Most of the time - 2 A good bit of the time - 3
    Some of the time - 4 A little bit of the time - 5 None of the time - 6

12. **Requires special care or equipment?** Yes - 1 No -2